

Medicaid Cost Sharing Strawman for Adults

The Patient Protection and Affordable Care Act (ACA) defines a new, mandatory eligibility group of non-pregnant adults, between ages 19 and 65, with modified adjusted gross income up to 138 percent¹ of the federal poverty level. This group must receive benchmark or benchmark-equivalent coverage described under section 1937 of the Social Security Act, and modified by the ACA to include all essential health benefits – now known as the Alternative Benefit Plan (ABP). Based on proposed federal rules published January 22, 2013², some additional flexibility has been defined for the application of cost sharing (i.e., premiums and point-of-service) to Medicaid coverage in general.

This document provides an overview of the *potential* for cost sharing in Medicaid as described in the proposed rules and compared with current cost sharing in the Basic Health program³ and the Uniform Medical Plan for public employees and their dependents. It includes a “strawman” as an example of potentially enforceable, limited cost sharing that is consistent with the new ACA flexibility and meets Washington State’s goals for cost sharing. We are soliciting broad feedback on the implications to Medicaid beneficiaries, health care providers and managed care plans, to inform further deliberation.

GOALS IN CONSIDERING APPLICATION OF COST SHARING TO MEDICAID:

Application of cost sharing to Medicaid coverage is considered among the overarching goals and principles to apply to the ACA Medicaid expansion and consistent with cost sharing applied to low-income populations covered primarily through the Basic Health program. Any discussion must address how cost sharing will:

- Promote use of evidence-based care and demonstrated best practices to reduce low-value and medically unnecessary care
- Avoid discouraging or creating barriers to essential and appropriate care
- Continue the current policy direction for low-income adults to contribute to their health care
- Avoid transferring fiscal responsibility along with an undue and administrative collection burden to providers
- Leverage new federal financing opportunities to ensure the Medicaid expansion is fiscally sustainable
- Maintain continuity of the coverage and care experience for individuals who move among subsidized (insurance affordability program) coverage options and Medicare.

¹ The ACA sets Medicaid income eligibility at 133 percent of the FPL but with a 5 percent across the board disregard, that effectively becomes 138 percent of the FPL.

² <http://www.gpo.gov/fdsys/pkg/FR-2013-01-22/pdf/2013-00659.pdf>

³ As a result of the ACA, Washington was able to negotiate an 1115 Demonstration waiver (the Transitional Bridge) through which the Basic Health program receives federal match for enrollees who will transition to the Medicaid expansion or the Exchange for coverage beginning January 1, 2014. The Transitional Bridge waiver covers the period January 1, 2011 through December 31, 2013.

MODELING ASSUMPTIONS AND RELATED QUESTIONS:

Assumptions are being made to support actuarial modeling and assessment of the impact of cost sharing. However, unanswered questions remain which require additional feedback.

- Federal rules require that cost sharing be applied equally to managed care, fee-for-service and benchmark coverage. However this does not apply to new Medicaid expansion adults *above* 100 percent of the FPL under the provisions of “targeted” cost sharing. Our initial assessment is that adults above this threshold who are exempt from managed care would generally be exempt from cost sharing in any case. Furthermore, given the likelihood that many newly eligible adults will be very low income and receiving public coverage for the first time (ever) it appears that cost sharing could be most effectively enforced on a group-limited basis, i.e., applied to the new adult group over 100 percent of the FPL.
- Many newly eligible adults will transfer to Medicaid from the current Basic Health program where they have a history of cost sharing at levels much higher than allowed by Medicaid. Some personal responsibility for the cost of health care will be expected. ***We are very interested in current experience of providers collecting cost sharing for their patients covered by Basic Health and other private insurance for individuals under 200 percent of the FPL.***
- Managed care plans currently track deductible and out-of-pocket limits for Basic Health enrollees. We assume that they have systems in place to apply to the tracking of Medicaid cost sharing. However, given claims lag time and movement in and out of coverage (i.e., churn); accurate tracking of precise out-of-pocket expenditures is likely to be challenging. ***We are very interested in understanding the operational readiness and implications for health plans and providers. For example, is the tracking of out-of-pocket limits more easily achievable through a fixed monthly or annual out-of-pocket cap?***
- Current Washington State Administrative Code requires that all hospitals implement a sliding fee schedule for discounts from billed charges that apply to individuals with income between 100-200 percent of the FPL (adjusted for family size.) ***We are very interested in understanding administrative and fiscal implications associated with the interaction of cost sharing and charity care policies - for hospitals and patients. For example, would cost sharing for hospital services be assumed to be discounted, whether collected or not? Should initial cost sharing levels be set with some assumption that a percentage reduction would be required under the charity care rules?***
- While collection of cost sharing for non-emergent Emergency Room visits is theoretically allowed, the implementation restrictions (e.g., for someone presenting at 3:00 a.m.) appear to make it operationally impracticable⁴. ***We are very interested in understanding how hospitals and managed***

⁴ Hospital providing the care must first conduct an appropriate medical screening to determine that the individual does not need ER services. Before providing treatment and imposing cost sharing for a non-emergency service, hospital must:

- (1) Provide the individual with name and location of an available and accessible alternative non-ER provider
- (2) Ensure that the alternative provider can provide services to the individual in a timely manner with the imposition of a lesser cost sharing amount, and
- (3) Coordinate scheduling and provide a referral for treatment by this provider.

care plans might define “non-emergent” absent the use of a diagnosis list. We are also engaged in an ongoing discussion with other states and CMS on whether further changes should be made to this specific provision in the cost sharing rule and would appreciate applicable comments.

DRAFT - FOR COMMENT

COMPARISON OF COST SHARING BY ADULTS FOR MEDICAL SERVICES COVERED THROUGH PUBLIC PROGRAMS

The following table includes both premiums and point-of-service payments in cost sharing.

	Medicaid "Strawman"	Medicaid Options Under ACA Flexibility	Current Basic Health Member's Payment Responsibility	Public Employees' Uniform Medical Plan ⁵	Description of Current Basic Health Benefit ⁶
Target Population					
	Newly eligible adults with income 100-138% FPL, enrolled in managed care ⁷ Not applicable to exempt groups ⁸	Limited cost sharing for ER and Pharmacy is allowed for all Medicaid populations with broader flexibility above 100% FPL	Legal, resident individuals in families with gross income up to 200% FPL	Public employees and their dependents	
Premiums					
	None	Non-exempt adults <150% FPL – None Non-exempt adults >150% FPL – Yes, subject to maintenance of effort waiver	Varies by age, family income 100-125% FPL All ages - \$60 125-140% FPL 19-39 - \$66.16 40-54 - \$83.74 55-64 - \$143.20	Varies by family size, chosen managed care plan/product. E.g., (UMP Classic) \$77 employee only \$222 family	
Benefits/Services					

⁵ Source: http://www.ump.hca.wa.gov/docs/coc/ump_classic_2013_coc.pdf

⁶ Source: <http://www.basichhealth.hca.wa.gov/benefits/html>

⁷ Not applicable to Medicaid enrollees receiving services fee-for-service – these individuals are primarily exempt from cost sharing.

⁸ Some groups of adults are exempt from premiums, deductibles, and most cost-sharing charges described in this table. They include pregnant women (except that those above 150 percent FPL can be charged very modest premiums), terminally ill individuals receiving hospice care, institutionalized spend-down individuals, breast and cervical cancer patients, and Indians who receive services from Indian health care providers. These groups can be charged cost-sharing for non-emergency use of an emergency department and for use of a non-preferred prescription drug. Further details on exemptions are included at the end of this document.

	Medicaid "Strawman"	Medicaid Options Under ACA Flexibility	Current Basic Health Member's Payment Responsibility	Public Employees' Uniform Medical Plan ⁵	Description of Current Basic Health Benefit ⁶
Out of Pocket Limit	\$240/year (~2% of annual income)	5% of annual income - or \$560 for single adults at 100% FPL	\$250 deductible; then 20% coinsurance (as noted) up to out-of- pocket annual maximum of \$1,500 – no out-of-pocket limit for pharmacy or ER	\$250 deductible (individual) / \$750 deductible (family of 3 or more) and coinsurance (as noted) up to out-of- pocket annual maximum of \$2,000 (individual) / \$4,000 (family)	
Preventive care	No copay	Not allowed for children. The rule is unclear on its application for adults.	No copay	No copay	Includes routine physicals, immunizations, PAP tests, mammograms, and other screening and testing when provided as part of the preventive care visit.
Office visits	\$4	10% of Medicaid cost	\$15 copay	15% coinsurance	Copay is for office visit only and includes consultations, mental health and chemical dependency outpatient visits, office-based surgeries, and follow-up visits Copays do not apply to preventive care, laboratory, radiology services, radiation, and chemotherapy. Some services will be subject to coinsurance.
Pharmacy	\$1 Generics \$4 Brand Name	\$4 preferred drugs \$8 non-preferred drugs	Tier 1 - \$10 copay Tier 2 – 50% of the drug cost	Value tier 5% coins (max \$10) – no deductible Tier 1 (generics) 10% coins (max \$25) - no deductible Tier 2 (preferred) 30% coins (max \$75) – deductible applies Tier 3 (non-preferred) 50% coins (max \$150) - deductible applies	30-day supply Tier 1 includes generic drugs in health plan's preferred drug list (formulary) Tier 2 includes brand-name drugs in health plan's preferred drug list (formulary).

	Medicaid "Strawman"	Medicaid Options Under ACA Flexibility	Current Basic Health Member's Payment Responsibility	Public Employees' Uniform Medical Plan⁵	Description of Current Basic Health Benefit⁶
Non-Emergent ER visit	\$8 (Non-emergent cannot be defined by diagnosis list)	\$8 (Non-emergent cannot be defined by diagnosis list)	\$100 copay applies if person is not admitted	\$75 and 15% coinsurance	No copay if admitted; hospital coinsurance and deductible would apply.
Urgent care	\$4	10% of Medicaid cost	\$15 copay	15% coinsurance	Copay is for office visit only, when provided in an urgent care setting. Deductible and coinsurance apply to all other services.
Hospital, inpatient	\$50 per admission	50% of Medicaid cost for 1st day or 10% of total visit cost	20% coinsurance; deductible applies. \$300 maximum facility charge per admittance.	\$200 per day up to \$600 annual max and 15% coinsurance on professional fees	Facility charges may include, but are not limited to, room and board, prescription drugs provided while an inpatient and other services received as an inpatient. No charges for maternity care or when readmitted for the same condition within 90 days. If the member is eligible for the Maternity Benefits Program, maternity services can only be covered under Basic Health for 30 days following diagnosis of pregnancy. All other maternity services are covered through Medicaid program. See other professional services.
Hospital, outpatient	\$4	10% of Medicaid cost	20% coinsurance; deductible applies.	15% coinsurance	
Other professional services	\$4	10% of Medicaid cost	20% coinsurance; deductible applies.	15% coinsurance	Includes services received as an inpatient, including, but not limited to, surgeries, anesthesia, chemotherapy, radiation, and other types of inpatient and outpatient services.

	Medicaid "Strawman"	Medicaid Options Under ACA Flexibility	Current Basic Health Member's Payment Responsibility	Public Employees' Uniform Medical Plan⁵	Description of Current Basic Health Benefit⁶
Laboratory	No copay for non-hospital services \$4 for hospital-based services	10% of Medicaid cost	No copay or coinsurance for outpatient services. 20% coinsurance for inpatient hospital-based laboratory services.	15% coinsurance	Deductible applies to services with coinsurance.
Radiology	No copay for non-hospital services \$4 for hospital-based services	10% of Medicaid cost	20% coinsurance, except for outpatient x-ray and ultrasound.	15% coinsurance	Deductible applies to services with coinsurance.
Ambulance services	No copay	10% of Medicaid cost	20% coinsurance; deductible applies.	20% coinsurance	Includes approved transfers from one facility to another. No coinsurance if transfer is required by the health plan.
Physical therapy/ Occupational therapy /Speech therapy	\$4	10% of Medicaid cost	20% coinsurance; deductible applies.	15% coinsurance	Up to a combined maximum of 12 visits per year. (Of those, no more than six can be for chiropractic care.) Visits qualify only when used as post-operative treatment following reconstructive joint surgery. Visits must be within one year of surgery.
Durable Medical Equipment	\$4	10% of Medicaid cost		15% coinsurance	Covered only during inpatient hospital stay
Dental	Not currently applicable	10% of Medicaid cost		15% coinsurance	Limited to emergency dental services

COST SHARING EXEMPTIONS:

Per section 1916 of the Social Security Act (the Act) [42 U.S.C. 1396] specific populations and services are exempt from cost sharing. The following is a general list of populations and services for which point-of-service cost sharing is not allowed. However, nominal co-pays are allowed for non-preferred drugs and non-emergent ER use by exempt populations, but they are not enforceable.

- Children under 18 years of age (and, at the option of the State, individuals under 21, 20, or 19 years of age, or any reasonable category of individuals 18 years of age or over but under 21). *As of January 1, 2014, this effectively includes all children below 138% FPL and infants under age 1 below 185% FPL.*
- Foster children
- Disabled children
- Pregnant women
- Services to terminally ill beneficiaries receiving hospice
- Services to institutionalized individuals (or those receiving services in a home and community-based setting) who are required to spend most of their income for medical care costs.
- Family planning services and supplies including contraceptives and pharmaceuticals for which the can claim Federal match at the enhanced rate
- Indians who are eligible to receive, or have ever received, an item or service furnished by an Indian health care provider or through referral under contract with Indian Health Services
- Individuals receiving Medicaid coverage through the Breast and Cervical Cancer Treatment program
- Emergency services needed to evaluate or stabilize an emergency medical condition which means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—
 - (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
 - (ii) serious impairment to bodily functions, or
 - (iii) serious dysfunction of any bodily organ or part.

TIMELINE OVERVIEW – Critical Steps:

STEP	DATE	Done
Review cost sharing broad concepts (including potential strawman for newly eligible adults) with stakeholders, Leg staff (pre CMS guidance)	12/11/12 – 12/12/12	✓
CMS guidance on Alternative Benefit Plan design and cost sharing flexibility	1/14/13	✓
Consultant assessment of CMS guidance (Manatt)	1/22/13	✓
Comparison of cost sharing in selected WA public programs	1/26/13 – 2/4/13	✓
Review apparent cost sharing flexibility with stakeholders, Leg staff (post CMS guidance)	1/31/13 – 2/6/13	✓
Draft/distribute cost sharing strawman for public comment	2/4/13 – 2/8/13	✓
Determine cost sharing parameters for modeling fiscal impact	2/4/13 – 2/8/13	
Milliman modeling (using CFC caseload estimates)	2/8/13 – 2/22/13	
Compile preliminary results (fiscal modeling, initial public comment, implementation assessment)	2/18/13 – 2/25/13	
Review implications for revisions to strawman	Wk of 2/25/13	
Align fiscal modeling with Legislative budget timeline	3/1/13	
Develop State Plan Amendment incorporating public comment	Spring 2013	
State Plan Amendment request	Spring 2013	
Legislative expenditure authority for Medicaid expansion	Session end	
Implementation activities (contract amendments, consumer communications, system activities, programmatic policy & procedures, CMS approval of SPA etc.)	10/1/13 (MAGI eligibility determination Go-Live)	